My Care Plan Overview **Pending DOI Approval**

Overview of Concept

This plan consists of three different options that employees can choose from: Active, family or Independent. Each option is designed, by benefit structure and "unique services" offerings, to ***specifically accommodate a certain lifestyle.*** Rates for each option are the same, allowing you to choose the plan that best accommodates your current lifestyle situation and needs.

Unique Services Program

The unique services program allows for reimbursement for certain services. These services, as allowed under IRS tax code 213(d), if any, provided under an option are designed specifically to accommodate a specific lifestyle. These services are eligible for reimbursement on a Contract Year basis. This reimbursement allows for reimbursement for the unique services listed without an extra premium cost. Refer to the following Schedule of Benefits for specific details of the unique services, if any, provided under each option.

The Active Option

The target group for this Health Maintenance Organization (HMO) option is those individuals who have an active lifestyle who may feel they do not seek medical services very often and are mainly concerned with preventive care and the type of services offered through the Unique Services Program. Individuals in this category typically do not have any children and are not planning on having children in the near future. The strengths of this plan are the unique services reimbursements for LASIK surgery, gym memberships*, weight loss programs*, smoking cessation program fees (above and beyond those covered by their benefit plan), vitamins*, birth control pills, prescribed by a physician), sterilization services, routine vision care, dental treatments*, ambulance copayments and copayments for x-rays. Refer to the following Schedule of Benefits for the Unique Services Reimbursement maximum.

The Family Option

The target group for this Health Maintenance Organization (HMO) option is those individuals who have a family oriented lifestyle. These individuals typically will have children, under 18 years of age, in the home or are expecting to start a family. The strengths of this plan is the lower copayments for children's services.

The Independent Option

The target group for this Point of Service (POS) option is those individuals who are beginning to prepare for retirement while possibly still helping out older, college-aged dependents or elderly parents. Individuals in this group may or may not have older children out of the home. This strengths of this plan is that it provides out of area coverage for you and your dependents. This option offers unique services reimbursements for prescription drug costs, routine vision care, disease management classes*, dental treatments*, diagnostic devises*, alternative therapies*, qualified long-term care services and premiums, and hearing aids.

(1) Benefit Certification may be required (2) Not subject to Deductible (3) Benefits are limited to Reasonable and Customary Charges. You are responsible for any balance due above Reasonable and Customary Charges. (4) 15% penalty applies if Preauthorization is not obtained (5)Does not include or apply to penalty amounts, charges above reasonable and customary, prescription drug copays, or noncovered charges including charges incurred after the benefit maximum has been reached.) PHP pays 100% of covered charges after the out-of-pocket maximum is met and up to reasonable and customary when applicable. (6) Includes Coinsurance only – does not include deductible or copayments.

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Which My Care Option Is Best For Me and My Family?

1. **Are you willing to commit to seeing health care providers who are contracted with Presbyterian?**

Yes – If you are comfortable staying within Presbyterian's network, there are many financial advantages to choosing the *Active* or *Family* options.

No – The *Independent* option is the only one that provides benefits for non-emergent services received outside of Presbyterian's network.

2. **How old are any children that you will be enrolling under the plan?**

0 *(I will not be enrolling any children)* **-** Either the *Active* or the *Independent* option would be a reasonable choice as these options offer unique services reimbursements that are appealing to adults.

0-18 yrs All of the options offer coverage for Dependent children. However, the *Family* option may be best as the copayments are lower for children (i.e. $10 copay for a Primary Care Physician visit for a child, $30 for an adult).

18-25 yrs The *Independent* option does have out of area coverage for non-emergent services for you and your Dependents who may be temporarily out of the PHP Service Area.

3. **Has your physician recommended you or any covered member of you family to participate in exercise, such as joining a gym, in order to treat a medical condition?**

Yes **-** The *Active* option offers up to $150 of reimbursement toward a formal gym or health club membership*.

No- *The family and Independent* options do not offer any reimbursement toward gym or health club membership, but do have other advantages.

4. **Do you receive chiropractic or acupuncture services?**

Yes **-** The *Independent* option offers up to $250 of reimbursement toward alternative therapies that include yoga, acupuncture and chiropractic services.

No **-** The *Active and Family* options only offer limited medically necessary benefits for acupuncture and chiropractic services.

5. **Do you plan on purchasing any of the following items or services? LASIK vision correction surgery, gym membership*, formal weight loss programs*, vitamins*, birth control pills, sterilization services, routine vision care, or dental treatments*.**

Yes – The *Active* option provides up to $150 of reimbursement toward the above services.

No **-** The *Family and Independent* options do not offer any reimbursements towards these services, but do have other advantages.

6. **Do you plan on utilizing any of the following items or services? Prescription drug costs (with a prescription from a physician), routine vision care, disease management classes*, alternative therapies*, dental treatments*, diagnostic devises* Qualified long term care services and premiums, hearing aids.**

Yes **-** The *Independent* option provides up to $250 of reimbursement toward the above services.

No **-** *Active* and *Family* options do not offer any reimbursements towards these services, but do have other advantages.

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The following Schedule of Benefits is a summary that describes the Copayment and Coinsurance amounts that apply to specific types of services. Some benefits require Benefit Certification by PHP. Benefits may have limits and certain services are excluded altogether. When the Copayment is expressed as a percentage, the percentage will be applied to the Total Allowable Charges for the particular procedure allowed by PHP. For a more complete description, please refer to the sections of the Group Subscriber Agreement that discuss How the Plan Works, General Information, Benefits, Benefit Certifications, Limitations and Exclusions.

My Care Benefits and Coverage	Copayment			
	Active Plan HMO (CK)	Family Plan HMO (CL)	Independent Plan POS (LR)	
			In-Network	Out-of-Network[3]
ANNUAL DEDUCTIBLE – Does not apply to out of pocket maximum	None	None	None	$500 per Individual / $1,500 per family Deductible must be met before payments are made
ANNUAL OUT-OF-POCKET MAXIMUM	2 x annual premium [5]	2 x annual premium [5]	2 x annual premium [5]	$6,000 per Individual[5,6] $18,000 per family[5,6]
MAXIMUM LIFETIME BENEFIT	Unlimited	Unlimited	Unlimited	$2,000,000
MAXIMUM LIFETIME TRANSPLANT BENEFIT	$500,000 (Including Immunosuppressive drugs)	$500,000 (Including Immunosuppressive drugs)	$500,000 (Including Immunosuppressive drugs)	**Not Covered**
UNIQUE SERVICES PROGRAM Refer to the Group Subscriber Agreement for more details.	$150 reimbursement per family per Contract Year for: • Gym memberships* • weight loss programs* • routine vision care* • smoking cessation (above and beyond those covered by their benefit plan) • vitamins* • Birth control pills prescribed by a physician • sterilization services • LASIK surgery • dental treatments* • ambulance copayments • copayments for X-rays * If recommended by a Physician to treat a specific medical condition. A note or Prescription from the Provide and the Unique Services Reimbursement Form must be submitted.	**None**	• $250 reimbursement per family per Contract Year for: • Prescription Drug costs with a prescription from a physician • Routine vision care • disease management classes* • alternative therapies* • dental treatments* • diagnostic devises* • qualified long term care services and premiums • hearing aides * If recommended by a Physician to treat a specific medical condition. A note or Prescription from the Provide and the Unique Services Reimbursement Form must be submitted.	

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My Care Benefits and Coverage	Copayment			
	Active Plan HMO (CK)	Family Plan HMO (CL)	Independent Plan POS (LR)	
			In-Network	Out-of-Network[3]
PHYSICIAN SERVICES including:				
Office Visits (OV)				
Primary Care Physician (PCP)	$20 copay per visit	$25 copay per visit – Adult $10 copay per visit – Child	$25 copay per visit	(Non-Specialist) 40%
Specialist	$30 copay per visit	$35 copay per visit – Adult $20 copay per visit – Child	$35 copay per visit	40%
Home visits if Medically Necessary	$30 copay per visit	$35 copay per visit – Adult $20 copay per visit - Child	$35 copay per visit	40%
Outpatient Surgery (In Physician's office)	Included in OV copay	Included in OV copay	Included in OV copay	40%
Specialty Pharmaceuticals[1] (Injectable forms administered in Physician's office)	$55 per injection	$50 per injection	$50 per injection	**Not Covered**
Allergy Services				
Testing	20% copay	20% copay	20% copay	40%
Serum (extracts)	20% copay	20% copay	20% copay	40%
Injections	Included in OV copay (waived if nursing visit only)	Included in OV copay (waived if nursing visit only)	Included in OV copay (waived if nursing visit only)	40%
Injections such as insulin, heparin and antibiotics	Included in OV copay (waived if nursing visit only)	Included in OV copay (waived if nursing visit only)	Included in OV copay (waived if nursing visit only)	40%
Infertility Services including drugs and injections[1]	50% copay	50% copay	50% copay	**Not Covered**
On-campus Student Health Center	$20 copay per visit	$25 copay per visit – Adult $10 copay per visit - Child	$25 copay per visit	$25 copay per visit
Hospital and Skilled Nursing Care visits	No copay	No copay	No copay	40%

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	Active Plan HMO (CK)	Family Plan HMO (CL)	Independent Plan POS (LR)	
			In-Network	Out-of-Network[3]
HOSPITAL SERVICES – Inpatient[1]				
Coverage Includes: • Room and Board • In-hospital Physician visits, Surgeons, Anesthesiologist and other Inpatient Services • For Newborn Delivery and other hospital Obstetrical Services refer to Women's Health Care	$150 per day up to a maximum of $450 per admission	$150 per day up to a maximum of $450 per admission – Adult $100 per day up to a maximum of $300 child per admission - Child	$150 per day up to a maximum of $450 per admission	40%[4]
MEDICAL SERVICES – Outpatient				
Surgeries[1] (at facility)	$150 copay per visit	$200 copay per visit - Adult $100 copay per visit - child	$125 copay per visit	40% [4]
X-ray and laboratory tests	No copay	No copay	No copay	40%
PET(1)/MRI Scans	$125 per test	$200 per test – Adult $100 per test - Child	$125 per test	40%[4]
Cardiac Cath	$200 per visit	$300 per visit – Adult $175 per visit - Child	$200 per visit	40%[4]
GI lab	$175 per visit	$175 per visit – Adult $150 per visit - Child	$175 per visit	40%[4]
Cat Scan	$75 per test	$125 per test – Adult $75 per test - Child	$75 per test	40%[4]
Radiation/Chemotherapy (Non-Surgical)	No copay	No copay	No copay	40%[4]
Chemotherapy	No copay	No copay	No copay	40% [4]
Specialty Pharmaceuticals[1]	$55 copay per injection	$50 copay per injection	$50 copay per injection	$50 copay per injection
Sleep Studies				
• No overnight stay	$50 copay per visit	$50 copay per visit	$50 copay per visit	40%
• Overnight stay	$100 copay per admission	$100 copay per admission	$100 copay per admission	40%
Administration of blood/blood components	No copay	No copay	No copay	40%
EMERGENCY ROOM CARE Including Trauma Services	$75 copay	$75 copay (Adult & child)	$75 copay	$75 copay[2]
URGENT CARE				
• Participating Provider/Practitioner	$25	$35 – Adult $20 - Child	$35	NA
• Non-Participating Provider/Practitioner	$50	$45 – Adult $30 - Child	NA	$45[2]

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	Active Plan HMO (CK)	Family Plan HMO (CL)	Independent Plan POS (LR)	
			In-Network	Out-of-Network[3]
AMBULANCE SERVICES including:				
Emergency or High-Risk				
• Ground Ambulance	$50 copay per occurrence	$50 copay per occurrence	$50 copay per occurrence	$50 copay per occurrence
• Air ambulance	$100 copay per occurrence	$100 copay per occurrence	$100 copay per occurrence	$100 copay per occurrence
Inter-Facility Transfer Services				
• Ground ambulance	No copay	No copay	No copay	No copay
• Air ambulance	$100 copay per occurrence	$100 copay per occurrence	$100 copay per occurrence	$100 copay per occurrence
CLINICAL PREVENTIVE SERVICES				
Well child care including vision & hearing screening	$15 copay	$5 copay per visit	$15 copay	40% [2]
Preventive physical exam	$15 copay	$20 copay – Adult $5 copay - Child	$15 copay	40% [2]
Adult and child immunizations	Included in OV copay (waived if nursing visit only)	Included in OV copay (waived if nursing visit only)	Included in OV copay (waived if nursing visit only)	40% [2]
Office Based Health education	Included in OV copay	Included in OV copay	Included in OV copay	40% [2]
Left-sided colon examination	Included in OV copay	Included in OV copay	Included in OV copay	40% [2]
Glaucoma testing	Included in OV copay	Included in OV copay	Included in OV copay	40% [2]
Family planning services	Included in OV copay	Included in OV copay	Included in OV copay	40% [2]
Health Education	Included in OV copay	Included in OV copay	Included in OV copay	40% [2]
Cytologic Screening (Pap Smear)	Included in OV copay	Included in OV copay	Included in OV copay	40% [2]
Mammography	No copay	No copay	No copay	40% [2]
WOMEN'S HEALTH CARE				
Gynecological Care	$20 OV copay	$25 OV copay – Adult $10 OV copay - Child	$25 OV copay	40%
In office Obstetrical/ Maternity Care/Prenatal & Postnatal care	$20 copay per visit up to a maximum of $200 per pregnancy	$25 copay per visit up to a maximum of $250 per pregnancy (Adult & Child)	$25 copay per visit up to a maximum of $250 per pregnancy	40%
Specialist (Perinatologist)	$30 copay per visit not included in per pregnancy maximum	$35 copay per visit not included in pregnancy maximum (Adult & Child)	$35 copay per visit not included in pregnancy maximum	40%

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			In-Network	Out-of-Network[3]
WOMEN'S HEALTH CARE *cont.…*				
Newborn Delivery and other hospital Obstetrical Services	$150 per day up to a maximum of $450 per admission	$150 per day up to a maximum of $450 per admission – Adult and child	$150 per day up to a maximum of $450 per admission	40%[4]
Implantable Contraceptive Devices				
• Insertion	50% copay per insertion	50% copay per insertion	50% copay per insertion	50%
• Removal	Included in OV copay	Included in OV copay	Included in OV copay	40%
DIABETES SERVICES				
Diabetes Education	Included in OV copay	Included in OV copay	Included in OV copay	40%
Diabetes Supplies (Durable Medical Equipment) [1]	50% copay (when purchased through a Participating Durable Medical Equipment Supplier)	50% copay (when purchased through a Participating Durable Medical Equipment Supplier)	50% copay (when purchased through a Participating Durable Medical Equipment Supplier)	50% [4]
Diabetic Supplies (Purchased through a Participating Pharmacy)	$10 generic (Preferred) / $35 brand (Preferred) / $55 Non-Preferred copay (30-day supply or 100 units, whichever is less)	$10 generic (Preferred) / $30 brand (Preferred) / $50 Non-Preferred copay (30-day supply or 100 units, whichever is less)	$10 generic (Preferred) / $30 brand (Preferred) / $50 Non-Preferred copay (30-day supply or 100 units, whichever is less)	**Not Covered** (Must use a Participating Pharmacy, unless required due to an emergency occurring outside of the PHP Service Area.)[2]
Insulin and diabetic oral agents for controlling blood sugar Generic (Preferred) Brand (Preferred) Non-Preferred	$10 copay $35 copay $55 copay Per 30-day supply or 100 tablets, whichever is less or per pre-packaged item	$10 copay $30 copay $50 copay Per 30-day supply or 100 tablets, whichever is less or per pre-packaged item	$10 copay $30 copay $50 copay Per 30-day supply or 100 tablets, whichever is less or per pre-packaged item	**Not Covered** (Must use a Participating Pharmacy, unless required due to an emergency occurring outside of the PHP Service Area.) [2]

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	Active Plan HMO (CK)	Family Plan HMO (CL)	Independent Plan POS (LR)	
			In-Network	Out-of-Network[3]
PRESCRIPTION DRUGS & COVERED MEDICATIONS (RETAIL)				
Generic (Preferred)	$10 copay (30-day supply or 100 units, whichever is less)	$10 copay (30-day supply or 100 units, whichever is less)	$10 copay (30-day supply or 100 units, whichever is less)	**Not Covered** (Must use a Participating Pharmacy, unless required due to an emergency occurring outside of the PHP Service Area.) [2]
Brand (Preferred)	$35 copay (30-day supply or 100 units, whichever is less)	$30 copay (30-day supply or 100 units, whichever is less)	$30 copay (30-day supply or 100 units, whichever is less)	
Brand (when a generic equivalent is available)	Generic copay plus the difference in the cost of the brand and generic per 30-day supply or 100 units, whichever is less	Generic copay plus the difference in the cost of the brand and generic per 30-day supply or 100 units, whichever is less	Generic copay plus the difference in the cost of the brand and generic per 30-day supply or 100 units, whichever is less	
Non-Preferred & Specialty Pharmaceuticals*	$55 copay (30-day supply or 100 units, whichever is less)	$50 copay (30-day supply or 100 units, whichever is less)	$50 copay (30-day supply or 100 units, whichever is less)	
Pre-packaged items	Applicable copay (generic, brand, Non-Preferred) per pre-packaged item			
PRESCRIPTION DRUGS (MAIL ORDER)				
Generic (Preferred)	2 x generic copay (90-day supply or 300 units, whichever is less)			**Not Covered** (Must use Participating Pharmacy.)
Brand (Preferred)	2.5 x brand copay (90-day supply or 300 units, whichever is less)			
Brand (when a generic equivalent is available)	2 x generic copay plus the difference in the cost of the brand and generic (90-day supply or 300 units, whichever is less)			
Non-Preferred (Specialty Pharmaceuticals are not available through mail order)	3 x Non-Preferred copay (90-day supply or 300 units, whichever is less)			
Pre-packaged items	Applicable mail order copay (generic, brand, Non-Preferred) / pre-packaged item			
MENTAL HEALTH				
Outpatient *	$30 copay per visit	$35 copay per visit - Adult $20 copay per visit - Child	$35 copay per visit	40%[4]
Inpatient* and partial hospitalization*	$150 per day up to a maximum of $450 per admission	$150 per day up to a maximum of $450 per admission – Adult $100 per day up to a maximum of $300 per admission	$150 per day up to a maximum of $450 per admission	40%[4]

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	Active Plan HMO (CK)	Family Plan HMO (CL)	Independent Plan POS (LR)	
			In-Network	Out-of-Network[3]
SUBSTANCE ABUSE				
Detoxification – outpatient*	$30 copay per visit	$35 copay per visit -Adult $20 copay per visit -Child	$35 copay per visit	40%[4]
Detoxification - Inpatient*	$150 per day up to a maximum of $450 per admission	$150 per day up to a maximum of $450 per admission – Adult $100 per day up to a maximum of $300 per admission -Child	$150 per day up to a maximum of $450 per admission	40%[4]
Rehabilitation Outpatient* (limited to 20 visits per calendar year)	$30 copay per visit	$35 copay per visit -Adult $20 copay per visit -Child	$35 copay per visit	40%
Rehabilitation Inpatient* and partial hospitalization* (limited to 30 days per calendar year)	25% copay per admission	25% copay per admission	25% copay per admission	40%[4]
Combined inpatient and outpatient substance abuse services are limited to 1 episode of treatment per calendar year, 3 episodes of treatment per lifetime				
REHABILITATION AND THERAPY SERVICES				
Cardiac Rehabilitation (up to 12 sessions continuous & 24 sessions intermittent ECG monitoring per Calendar Year)	$20 copay per visit	$25 copay per visit -Adult $10 copay per visit -Child	$25 copay per visit	**Not Covered**
Dialysis/Plasmapheresis/ Photophoresis	20% copay per visit	20% copay per visit	20% copay per visit	40%
Pulmonary Rehabilitation (up to 24 sessions per year)	$20 copay per visit	$25 copay/ visit - Adult $10 copay/visit - Child	$25 copay per visit	**Not Covered**
Short-term Rehabilitation[1] (Physical & Occupational Therapy up to 2 months per condition)				
• Inpatient[1]	$150 per day up to a maximum of $450 per admission	$150 per day up to a maximum of $450 per admission – Adult $100 per day up to a maximum of $300 per admission -Child	$150 per day up to a maximum of $450 per admission	40% [4]
• Outpatient[1]	$30 copay per visit	$35 copay/visit – Adult $20 copay/visit – Child	$35 copay per visit	40% [4]
Speech and Hearing Therapy[1] (up to 2 months per condition)	$30 copay per visit	$35 copay/visit - Adult $20 copay/visit - Child	$35 copay per visit	**Not Covered**

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	Active Plan HMO (CK)	Family Plan HMO (CL)	Independent Plan POS (LR)	
			In-Network	Out-of-Network[3]
TRANSPLANTS[1] (Subject to lifetime transplant maximums)	$150 per day up to a maximum of $450 per admission	$150 per day up to a maximum of $450 per admission – Adult $100 per day up to a maximum of $300 per admission -Child	$150 per day up to a maximum of $450 per admission	**Not Covered**
COMPLEMENTARY THERAPIES (Limited)				
Acupuncture Services (up to 20 visits per calendar year if medically necessary)	$30 copay per visit	$35 copay/visit – Adult $20 copay/visit – Child	$35 copay per visit	40%
Chiropractic Services (up to 18 visits per calendar year if medically necessary)	$30 copay per visit	$35 copay/ visit – Adult $20 copay/visit - Child	$35 copay per visit	40%
Biofeedback for specific conditions	$20 copay per visit	$25 copay/ visit - Adult $10 copay/visit - Child	$25 copay per visit	40%
SKILLED NURSING FACILITY[1] (Up to 60 days per Calendar Year)	$150 per day up to a maximum of $450 per admission	$150 per day up to a maximum of $450 per admission – Adult $100 per day up to a maximum of $300 per admission -Child	$150 per day up to a maximum of $450 per admission	40% [4]
HOME HEALTH CARE SERVICES[1]**/ HOME INTRAVENOUS SERVICES**[1]				
Services provided by an RN, LPN and other specified specialist[1]	No copay	No copay	No copay	40% [4]
Home intravenous services and supplies[1]	No copay	No copay	No copay	40% [4]
Specialty Pharmaceuticals[1] (Injectable forms administered by a Home Healthcare professional)	$55 copay per injection	$50 copay per injection	$50 copay per injection	$50 copay per injection

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	Active Plan HMO (CK)	Family Plan HMO (CK)	Independent Plan POS (LR)	
			In-Network	Out-of-Network[3]
HOSPICE CARE[1]				
Inpatient[1]	$150 per day up to a maximum of $450 per admission	$150 per day up to a maximum of $450 per admission – Adult $100 per day up to a maximum of $300 per admission - Child	$150 per day up to a maximum of $450 per admission	40% [4]
In-home[1]	No copay	No copay	No copay	40% [4]
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND APPLIANCES[1]	50% copay	50% copay	50% copay	50% [4]
EYEGLASSES AND CONTACT LENSES			In-Network	Out-of-Network[3]
Limited to the following:				
• Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of Keratoconus	50% copay	50% copay	50% copay	**Not Covered** (However, services are available through your VSP vision rider and the Unique Services Reimbursement Program.)
• Refraction Eye Exam associated with post cataract surgery or Keratoconus correction	Included in OV copay	Included in OV copay	Included in OV copay	
DENTAL SERVICES/TMJ/CMJ (Limited)	Included in OV copay	Included in OV copay	Included in OV copay	40%

[1] Benefit Certification may be required [2] Not subject to Deductible [3] Benefits are limited to Reasonable and Customary Charges. You are responsible for any balance due above Reasonable and Customary Charges. [4] 15% penalty applies if Preauthorization is not obtained [5]Does not include or apply to penalty amounts, charges above reasonable and customary, prescription drug copays, or noncovered charges including charges incurred after the benefit maximum has been reached.) PHP pays 100% of covered charges after the out-of-pocket maximum is met and up to reasonable and customary when applicable. [6] Includes Coinsurance only – does not include deductible or copayments.